THE SENATE
TWENTY-NINTH LEGISLATURE, 2017
STATE OF HAWAII

S.B. NO. 403 S.D. 1

A BILL FOR AN ACT

RELATING TO HEALTH INSURANCE.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

SECTION 1. The legislature finds that the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act) has resulted in an estimated 20,000,000 Americans gaining health insurance coverage. The provisions under the Affordable Care Act that afforded coverage to the uninsured include the medicaid expansion, health insurance marketplace coverage, and changes in private insurance that permit young adults to remain on their parent's health insurance plans and require health insurance plans to cover people with preexisting health conditions. According to a report from the United States Department of Health and Human Services, 6,100,000 uninsured young adults ages nineteen to twenty-five have gained health insurance coverage thanks to the Affordable Care Act. This is especially important as young adults were particularly likely to be uninsured before the law went into effect.

The federal Department of Health and Human Services recently reported that since the enactment of the Affordable Care Act, 54,000 residents of Hawaii have gained health

insurance coverage. In addition to residents who would otherwise be uninsured, hundreds of thousands of Hawaii residents with employer, medicaid, individual market, or medicare coverage have also benefited from new protections under the Affordable Care Act. Even with the robust coverage of Hawaii's Prepaid Health Care Act, the benefits of the Affordable Care Act in Hawaii have been widespread. The Act expanded medicaid eligibility and strengthened the program for those already eligible. The State has saved millions in uncompensated care costs and has been able to improve behavioral health outcomes for various beneficiaries. For Hawaii residents, individual market coverage is now dramatically better than before the enactment of the Affordable Care Act.

Unfortunately, the future of the Affordable Care Act is now uncertain. The new Presidential Administration campaigned on the promise to repeal the Affordable Care Act. Republicans in Congress have also backed the new President's promise to repeal and replace the Affordable Care Act. On January 12, 2017, Senate Republicans took their first major step toward repealing the Affordable Care Act, when they approved a budget blueprint that would allow Republicans to gut the Affordable Care Act

without the threat of a Democratic filibuster. On January 20, 2017, the President signed his first Executive Order, directing federal agencies to waive enforcement of large swaths of the law.

The repeal of the Affordable Care Act will have widespread ramifications. According to recent data from the Urban Institute, 86,000 fewer people in Hawaii would have health insurance in 2019 if the Affordable Care Act is repealed. States are poised to lose significant federal funds if marketplace subsidies and the medicaid expansion end. For Hawaii, a repeal of the Affordable Care Act means the loss of $47,000,000 in federal marketplace spending in 2019 and a loss of $532,000,000 between 2019 and 2028. Hawaii would also lose $306,000,000 in federal medicaid funding in 2019 and $3,700,000,000 between 2019 and 2028.

The legislature further finds that repealing the Affordable Care Act would destabilize the individual insurance market, due to a combination of several factors, including the pending loss of subsidies, elimination of the requirement to buy health insurance, and elimination of the requirement that insurers sell to all consumers. Such factors will likely cause individual

insurance prices to rise and may cause healthier individuals to drop health insurance coverage.

The Urban Institute estimates that repealing the Affordable Care Act without an adequate replacement plan that ensures affordable coverage would take health insurance coverage away from 29,800,000 people nationwide by 2019, more than doubling the total number of uninsured to 58,700,000.

As of January 2017, there is not yet a firm plan or agreement regarding the future of the Affordable Care Act. However, the new President has demanded Congress immediately repeal and replace the Act. The legislature concludes that due to the uncertainty over the Affordable Care Act, it is important to preserve certain important aspects of the Act for residents in Hawaii.

Accordingly, the purpose of this Act is to ensure certain benefits under the Affordable Care Act, which may not otherwise be available under the State's Prepaid Health Care Act, remain available under Hawaii law, including:

(1) Preserving the individual mandate that requires taxpayers to have qualified health insurance coverage throughout the year or pay a penalty;

(2) Preserving the premium tax credit for individuals and families with low or moderate income;

(3) Ensuring all health insurers, mutual benefit societies, and health maintenance organizations in the State, including health benefits plans under chapter 87A, Hawaii Revised Statutes, include ten essential health care benefits, plus additional contraception and breastfeeding coverage benefits;

(4) Extending dependent coverage for adult children until the children turn twenty-six years of age;

(5) Prohibiting health insurance entities from imposing a preexisting condition exclusion;

(6) Prohibiting health insurance entities from using an individual's gender to determine premiums or contributions; and

(7) Prohibiting health insurance entitles from discriminating with respect to participation against a health care provider acting within the scope of that provider's license or certification.

SECTION 2. Chapter 235, Hawaii Revised Statutes, is amended by adding two new sections to be appropriately designated and to read as follows:

"**§235- Minimal essential coverage.** (a) For each month beginning after December 31, 2017, an individual shall ensure that the individual, and any dependent of the individual, is covered with minimum essential coverage for the month.

(b) If a taxpayer, or a dependent for whom the taxpayer is liable under paragraph (2), fails to meet the requirement of subsection (a) for one or more months, then a penalty shall be imposed on the taxpayer in an amount determined pursuant to subsection (c); provided that:

(1) Any penalty imposed by this section with respect to any month shall be included with a taxpayer's return under section 235-92 for the taxable year which includes that month; and

(2) If a penalty is imposed for any month on an individual and the individual:

(A) Is a dependent of another taxpayer for the other taxpayer's taxable year, the other taxpayer shall be liable for the penalty; or

(B) Files a joint return for the taxable year, the individual and the spouse of the individual shall be jointly liable for such penalty.

(c) The amount of the penalty imposed by this section on any taxpayer for any taxable year pursuant to subsection (b) shall be equal to the sum of the monthly penalty amounts determined under subsection (d) for months in the taxable year during which one or more such failures occurred.

(d) The monthly penalty amount with respect to any taxpayer for any month during which any failure described pursuant to subsection (b) occurred is an amount equal to one-twelfth of the greater of the following amounts:

(1) A flat rate of $695; or

(2) 2.5 per cent of the excess of the taxpayer's household income for the taxable year over the taxpayer's applicable filing threshold, as determined under this chapter, for the taxable year.

(e) If an individual has not attained the age of eighteen as of the beginning of a month, the monthly penalty amount with respect to such individual shall be equal to one-half of the amount described in subsection (d).

(f) For every calendar year beginning after December 31, 2018, the amount under subsection (d)(1) shall be $695, increased by an amount equal to $695 multiplied by the cost of living adjustment determined pursuant to title 26 United States Code section 1(f)(3).

(g) For purposes of this section:

"Household income" means, with respect to any taxpayer for any taxable year, an amount equal to the sum of the adjusted gross income, as determined under this chapter, of the taxpayer plus the aggregate adjusted gross income, as determined under this chapter, of all individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) of the Internal Revenue Code of 1986, as amended, for the taxable year and who were required to file a tax return under section 235-92.

"Minimum essential coverage" has the same meaning as in section 5000A(f) of the Internal Revenue Code of 1986, as amended, and title 26 Code of Federal Regulations section 1.5000A-2, as of January 1, 2017.

§235- Coverage under a qualified health plan; income tax credit. (a) There shall be allowed to each qualified taxpayer

a qualified health plan coverage income tax credit that shall be deductible from the qualified taxpayer's net income tax liability, if any, imposed by this chapter for the taxable year in which the credit is properly claimed.

(b) The qualified health plan coverage income tax credit shall be equal to per cent of the actual cost paid or incurred by a qualified taxpayer in the taxable year to purchase minimum essential coverage for the qualified taxpayer, the qualified taxpayer's spouse, or any dependent of the qualified taxpayer; provided that the amount of the credit shall not include any amounts paid or incurred by a qualified taxpayer for minimum essential coverage purchased for an individual who has health coverage under a government-sponsored program or employer-sponsored plan. The total amount claimed by a qualified taxpayer for the qualified health plan coverage tax credit shall not exceed $ in any taxable year.

(c) If the tax credit claimed by the qualified taxpayer under this section exceeds the amount of the income tax payments due from the qualified taxpayer, the excess of credit over payments due shall be refunded to the qualified taxpayer; provided that no refunds or payments on account of the tax

credit allowed by this section shall be made for amounts less than $1.

(d) Claims for the tax credit under this section, including any amended claims, shall be filed on or before the end of the twelfth month following the taxable year for which the credit may be claimed. Failure to comply with this subsection shall constitute a waiver of the right to claim the credit.

(e) For purposes of this section:

"Family size" means the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) of the Internal Revenue Code of 1986, as amended, for the taxable year.

"Household income" means, with respect to any taxpayer for any taxable year, an amount equal to the sum of the adjusted gross income, as determined under this chapter, of the taxpayer plus the aggregate adjusted gross income, as determined under this chapter, of all individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) of the Internal Revenue Code

of 1986, as amended, for the taxable year and who were required to file a tax return under section 235-92.

"Minimum essential coverage" means the same as in section 5000A(f) of the Internal Revenue Code of 1986, as amended, and title 26 Code of Federal Regulations 1.5000A-2, as of January 1, 2017.

"Qualified taxpayer" means an individual:

(1) Who files an individual income tax return for the taxable year;

(2) Who is not claimed or is not otherwise eligible to be claimed as a dependent by another taxpayer for federal or Hawaii state individual income tax purposes;

(3) Who has been physically present in the State for more than nine months during the taxable year;

(4) Whose household income for the taxable year does not exceed per cent of the federal poverty guideline for Hawaii, as most recently published by the United States Department of Health and Human Services for the taxpayer's family size; and

(5) Who, if married at the close of the taxable year, files a joint return for the taxable year; provided

that this paragraph shall not apply to a married taxpayer who is unable to file a joint return because the taxpayer is a victim of domestic abuse or spousal abandonment and is living apart from the taxpayer's spouse at the time the taxpayer files the return."

SECTION 3. Chapter 431, Hawaii Revised Statutes, is amended by adding five new sections to article 10A to be appropriately designated and to read as follows:

"**§431:10A- Essential health care benefits.** (a) Every policy of accident and health or sickness insurance issued or renewed in this State shall include at least the following essential health care benefits:

(1) Ambulatory patient services;

(2) Emergency services;

(3) Hospitalization benefits;

(4) Pregnancy, maternity, and newborn care;

(5) Mental health and substance use disorder services, including behavioral health treatment, mental and behavioral health inpatient services, and substance use disorder treatment;

(6) Prescription drug coverage;

(7) Rehabilitative and habilitative services and devices;

(8) Laboratory services;

(9) Preventive and wellness services and chronic disease management; and

(10) Pediatric services, including oral and vision care.

(b) Policies of accident and health or sickness insurance delivered or issued for delivery in this State shall also include the following additional benefits:

(1) Contraceptive coverage, including:

(A) All federal Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider, for all women with reproductive capacity; provided that a policy or health insurer shall accommodate any individual for whom a particular generic or brand name drug would be medically inappropriate, as determined by the individual's health care provider, by establishing a mechanism for waiving otherwise applicable cost-sharing requirements

for the brand or non-preferred brand version of the drug; and

(B) Coverage for vasectomy and other federal Food and Drug Administration-approved contraceptive methods for men; and

(2) Breastfeeding coverage, including:

(A) Breastfeeding support;

(B) Breastfeeding counseling; and

(C) Equipment, including the coverage of a manual or electric breast pump and associated equipment as prescribed by an individual's health care provider,

for the duration of breastfeeding;

provided that a health insurer shall not impose any cost-sharing requirements, including copayments, coinsurance, or deductibles, on a policyholder or individual with respect to the benefits covered under this subsection.

(c) This section shall not apply to policies that provide coverage for specified diseases or other limited benefit coverage, as provided pursuant to section 431:10A-102.5.

§431:10A- Extension of dependent coverage. A group accident and health or sickness insurance policy and a health insurer offering group or individual accident and health or sickness insurance coverage that provides dependent coverage of children shall continue to make such coverage available for an adult child until the child turns twenty-six years of age. Nothing in this section shall require a policy or health insurer to make coverage available for a child of a child receiving dependent coverage.

§431:10A- Prohibition of preexisting condition exclusions. (a) An accident and health or sickness insurance policy issued or renewed in this State shall not impose any preexisting condition exclusion.

(b) For purposes of this section, a "preexisting condition exclusion" means a limitation or exclusion of benefits (including a denial of coverage) based on the fact that the condition was present before the effective date of coverage (or if coverage is denied, the date of the denial) under a group or individual accident and health or sickness insurance policy, whether or not any medical advice, diagnosis, care, or treatment

was recommended or received before that day and includes any condition.

The term "preexisting condition exclusion" includes any limitation or exclusion of benefits (including a denial of coverage) applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage (or if coverage is denied, the date of the denial) under a group or individual accident and health or sickness insurance policy, such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.

§431:10A- Prohibited discrimination in premiums or contributions. A group accident and health or sickness insurance policy and a health insurer offering group or individual accident and health or sickness insurance coverage issued or renewed in this State shall not require an individual, as a condition of enrollment or continued enrollment under the policy, to pay a premium or contribution based on the individual's gender that is greater than the premium or

contribution for a similarly situated individual of the opposite gender who is covered under the same policy.

§431:10A- Nondiscrimination in health care. (a) A group accident and health or sickness insurance policy and a health insurer offering group or individual accident and health or sickness insurance coverage issued or renewed in this State shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable state law.

(b) This section shall not require that a group accident and health or sickness insurance policy or a health insurer offering group or individual accident and health or sickness insurance coverage contract with any health care provider willing to abide by the terms and conditions established by the policy or health insurer.

(c) Nothing in this section shall be construed as preventing a group accident and health or sickness insurance policy or a health insurer offering group or individual accident and health or sickness insurance from establishing varying reimbursement rates based on quality or performance measures."

SECTION 4. Chapter 432, Hawaii Revised Statutes, is amended by adding five new sections to article 1 to be appropriately designated and to read as follows:

"**§432:1- Essential health care benefits.** (a) Every hospital or medical service plan contract issued or renewed in this State shall include at least the following essential health care benefits:

(1) Ambulatory patient services;

(2) Emergency services;

(3) Hospitalization benefits;

(4) Pregnancy, maternity, and newborn care;

(5) Mental health and substance use disorder services, including behavioral health treatment, mental and behavioral health inpatient services, and substance use disorder treatment;

(6) Prescription drug coverage;

(7) Rehabilitative and habilitative services and devices;

(8) Laboratory services;

(9) Preventive and wellness services and chronic disease management; and

(10) Pediatric services, including oral and vision care.

(b) Hospital or medical service plan contracts delivered or issued for delivery in this State shall also include the following additional benefits:

(1) Contraceptive coverage, including:

(A) All federal Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider, for all women with reproductive capacity; provided that a plan contract or mutual benefit society shall accommodate any individual for whom a particular generic or brand name drug would be medically inappropriate, as determined by the individual's health care provider, by establishing a mechanism for waiving otherwise applicable cost-sharing requirements for the brand or non-preferred brand version of the drug; and

(B) Coverage for vasectomy and other federal Food and Drug Administration-approved contraceptive methods for men; and

(2) Breastfeeding coverage, including:

(A) Breastfeeding support;

(B) Breastfeeding counseling; and

(C) Equipment, including the coverage of a manual or electric breast pump and associated equipment as prescribed by an individual's health care provider,

for the duration of breastfeeding;

provided that a mutual benefit society shall not impose any cost-sharing requirements, including copayments, coinsurance, or deductibles, on a member or subscriber with respect to the benefits covered under this subsection.

(c) This section shall not apply to policies that provide coverage for specified diseases or other limited benefit coverage, as provided pursuant to section 431:10A-102.5.

§432:1- Extension of dependent coverage. A group hospital or medical service plan contract and a mutual benefit society offering group or individual hospital and medical service plan contracts that provides dependent coverage of children shall continue to make such coverage available for an adult child until the child turns twenty-six years of age. Nothing in this section shall require a plan contract to make

coverage available for a child of a child receiving dependent coverage.

§432:1- Prohibition of preexisting condition exclusions. (a) A hospital or medical service plan contract issued or renewed in this State shall not impose any preexisting condition exclusion.

(b) For purposes of this section, a "preexisting condition exclusion" means a limitation or exclusion of benefits (including a denial of coverage) based on the fact that the condition was present before the effective date of coverage (or if coverage is denied, the date of the denial) under a group or individual hospital and medical service plan contract, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day and includes any condition.

The term "preexisting condition exclusion" includes any limitation or exclusion of benefits (including a denial of coverage) applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage (or if coverage is denied, the date of the denial) under a group or individual

hospital and medical service plan contract, such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.

§432:1- Prohibited discrimination in premiums or contributions. A group hospital or medical service plan contract and a mutual benefit society offering group or individual hospital and medical service plan contracts issued or renewed in this State shall not require an individual, as a condition of enrollment or continued enrollment under the plan contract, to pay a premium or contribution based on the individual's gender that is greater than the premium or contribution for a similarly situated individual of the opposite gender who is covered under the same plan contract.

§432:1- Nondiscrimination in health care. (a) A group hospital or medical service plan contract and a mutual benefit society offering group or individual hospital and medical service plan contracts issued or renewed in this State shall not discriminate with respect to participation under the plan contract against any health care provider who is acting within

the scope of that provider's license or certification under applicable state law.

(b) This section shall not require that a group hospital or medical service plan contract or a mutual benefit society offering group or individual hospital and medical service plan contracts contract with any health care provider willing to abide by the terms and conditions established by the plan contract or mutual benefit society.

(c) Nothing in this section shall be construed as preventing a group hospital or medical service plan contract or a mutual benefit society offering group or individual hospital and medical service plan contracts from establishing varying reimbursement rates based on quality or performance measures."

SECTION 5. Chapter 432D, Hawaii Revised Statutes, is amended by adding five new sections to be appropriately designated and to read as follows:

"**§432D- Essential health care benefits.** (a) Every health maintenance organization policy, contract, plan, or agreement issued or renewed in this State shall include at least the following essential health care benefits:

(1) Ambulatory patient services;

(2) Emergency services;

(3) Hospitalization benefits;

(4) Pregnancy, maternity, and newborn care;

(5) Mental health and substance use disorder services, including behavioral health treatment, mental and behavioral health inpatient services, and substance use disorder treatment;

(6) Prescription drug coverage;

(7) Rehabilitative and habilitative services and devices;

(8) Laboratory services;

(9) Preventive and wellness services and chronic disease management; and

(10) Pediatric services, including oral and vision care.

(b) Every health maintenance organization policy, contract, plan, or agreement delivered or issued for delivery in this State shall also include the following additional benefits:

(1) Contraceptive coverage, including:

(A) All federal Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider, for all

women with reproductive capacity; provided that a health maintenance organization shall accommodate any individual for whom a particular generic or brand name drug would be medically inappropriate, as determined by the individual's health care provider, by establishing a mechanism for waiving otherwise applicable cost-sharing requirements for the brand or non-preferred brand version of the drug; and

(B) Coverage for vasectomy and other federal Food and Drug Administration-approved contraceptive methods for men; and

(2) Breastfeeding coverage, including:

(A) Breastfeeding support;

(B) Breastfeeding counseling; and

(C) Equipment, including the coverage of a manual or electric breast pump and associated equipment as prescribed by an individual's health care provider,

for the duration of breastfeeding;

provided that a health maintenance organization shall not impose any cost-sharing requirements, including copayments, coinsurance, or deductibles, on an enrollee or subscriber with respect to the benefits covered under this subsection.

(c) This section shall not apply to policies that provide coverage for specified diseases or other limited benefit coverage, as provided pursuant to section 431:10A-102.5.

§432D- Extension of dependent coverage. A group contract and a health maintenance organization offering group or individual policies, contracts, plans, or agreements that provides dependent coverage of children shall continue to make such coverage available for an adult child until the child turns twenty-six years of age. Nothing in this section shall require a policy, contract, plan, or agreement to make coverage available for a child of a child receiving dependent coverage.

§432D- Prohibition of preexisting condition exclusions. (a) A health maintenance organization policy, contract, plan, or agreement issued or renewed in this State shall not impose any preexisting condition exclusion.

(b) For purposes of this section, a "preexisting condition exclusion" means a limitation or exclusion of benefits

(including a denial of coverage) based on the fact that the condition was present before the effective date of coverage (or if coverage is denied, the date of the denial) under a group or individual health maintenance organization policy, contract, plan, or agreement, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day and includes any condition.

The term "preexisting condition exclusion" includes any limitation or exclusion of benefits (including a denial of coverage) applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage (or if coverage is denied, the date of the denial) under a group or individual health maintenance organization policy, contract, plan, or agreement, such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.

§432D- Prohibited discrimination in premiums or contributions. A group contract and a health maintenance organization offering group or individual policies, contracts,

plans, or agreements issued or renewed in this State shall not require an individual, as a condition of enrollment or continued enrollment under a policy, contract, plan, or agreement, to pay a premium or contribution based on the individual's gender that is greater than the premium or contribution for a similarly situated individual of the opposite gender who is covered under the same policy, contract, plan, or agreement.

§432D- Nondiscrimination in health care. (a) A group contract and a health maintenance organization offering group or individual policies, contracts, plans, or agreements issued or renewed in this State shall not discriminate with respect to participation under the policy, contract, plan, or agreement against any health care provider who is acting within the scope of that provider's license or certification under applicable State law.

(b) This section shall not require that a group contract or a health maintenance organization offering group or individual policies, contracts, plans, or agreements contract with any health care provider willing to abide by the terms and conditions established by the group contract or health maintenance organization.

(c) Nothing in this section shall be construed as preventing a group contract or a health maintenance organization offering group or individual policies, contracts, plans, or agreements from establishing varying reimbursement rates based on quality or performance measures."

SECTION 6. Notwithstanding any other law to the contrary, the requirements for essential health care benefits, extension of dependent coverage, and prohibition of preexisting condition exclusions required under sections 3, 4, and 5 of this Act shall apply to all health benefits plans under chapter 87A, Hawaii Revised Statutes, issued, renewed, modified, altered, or amended on or after the effective date of this Act.

SECTION 7. New statutory material is underscored.

SECTION 8. This Act shall take effect on July 1, 2050; provided that the new section in chapter 235, Hawaii Revised Statutes, on minimal essential coverage, added by section 2 of this Act shall be repealed on June 30, 2021.

S.B. NO. 403 S.D. 1

Report Title:
Health Insurance; Individual Mandate; Tax Credit; Essential Benefits; Covered Services; Extended Coverage; Preexisting Conditions; Nondiscrimination

Description:
Ensures certain benefits under the federal Affordable Care Act are preserved under Hawaii law, including: preserving the individual health insurance mandate for taxpayers; preserving the premium tax credit for individuals and families with low or moderate income; requiring all health insurance entities, including health benefits plans under chapter 87A, HRS, to include ten essential health care benefits, plus additional contraception and breastfeeding coverage benefits; extending dependent coverage for adult children until the children turn twenty-six years of age; prohibiting health insurance entities from imposing a preexisting condition exclusion; prohibiting health insurance entities from using an individual's gender to determine premiums or contributions; and prohibiting health insurance entitles from discriminating with respect to participation against a health care provider acting within the scope of that provider's license or certification. Effective 7/1/2050. Individual mandate requirement repeals 6/30/2021. (SD1)

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